Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Fondren Orthopedic Gp, LLP

Respondent Name
New Hampshire Insurance Company

MFDR Tracking Number
M4-14-3792-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
August 29, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Per 28 Texas Administrative Code §133.307(c)(2) states, in relevant part, "The request shall include (N) a position statement of the disputed issue(s) that shall include: (i) the requestor's reasoning for why the disputed fees should be paid or refunded, (ii) how the Labor Code and division rules, including fee guidelines, impact the disputed fee issues, and (iii) how the submitted documentation supports the requestor's position for each disputed fee issue." Review of the submitted documentation does not find a position statement from the requestor.

Amount in Dispute: $63.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on September 8, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 18, 2013	Radiology	$63.62	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.10 defines the requirements for billing professional services by a health care provider.

3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for billing and reimbursing professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   From Explanation of Benefits dated, 1/13/14, for CPT Code 73564:
   - 22292 – CV: Documented procedure does not appear to match the code description of the CPT code billed.

   From Explanation of Benefits dated, 2/17/14, for CPT Code 73562:
   - 13V00 – Per CPT, code is denied based on the actual CPT code definition. Service included in another code billed on the same day.

Issues

1. Did the requestor support the disputed services?
2. Is the requestor entitled to reimbursement?

Findings

1. Review of the submitted Medical Fee Dispute Resolution Request (DWC060) does not find a request for a specific service code, but rather an undefined procedure on date of service 12/18/13 for a billed amount of $90.00. The submitted explanation of benefits dated 1/13/14 suggests that this procedure is for CPT code 73564-LT, as the date of service and billed amount match. CPT code 73564-LT is defined as a "radiologic examination, knee; complete, 4 or more views." This code would include both the professional and technical components, as no modifier was used to indicate one or the other. Review of the submitted documentation does not support this service.

   Alternatively, the submitted CMS-1500 and the explanation of benefits, dated 2/17/14, suggest that the requestor may have submitted a new bill, modifying the request to CPT code 73562-LT. CPT code 73562-LT is defined as a "radiologic examination, knee; 3 views." Further, the CPT Manual states that the procedure has "both a technical and professional component. To report only the professional component, append modifier 26 … To report the complete procedure (i.e., both the professional and technical components), submit without a modifier." Because the code was reported with only the LT modifier, indicating the left knee, the billed code would require documentation to show that both the professional and technical components were performed. Documentation submitted finds that the requestor was reviewing x-rays from an outside source. Therefore, this service was not supported.
2. Because the requestor did not support the disputed services, no reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	March 24, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.